Eastern Oklahoma Orthopedic Center, Inc.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

EOOC MEDICAL RECORDS F# 918)494-9395

PATIENT NAME	DATE OF BIRTH	SEX
		☐ M ☐ F
SOCIAL SECURITY NUMBER	PATIENT ACCOUNT NUMBER	TELEPHONE NUMBER
		( ) -

I hereby authorize Eastern Oklahoma Orthopedic Center and its agents and employees to release or obtain information and copies of records pertaining to my medical care and treatment.

☐ **RELEASE TO**

☐ **OBTAIN FROM**

INDIVIDUAL / FACILITY / COMPANY NAME

ADDRESS, CITY, STATE, ZIP

FAX#

Date(s) of Service: ALL DATES

Purpose of Request: ☐ Personal Records ☐ Further Treatment ☑ Insurance ☐ Legal

☐ Other: _____

This authorization will expire on _____ (consent date or event) or 12 months after the date of signature.

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE OR NONCOMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

1. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated.)
   - ☐ Complete Record
   - ☐ Pertinent information: Facesheet, Discharge Summary, History & Physical, Physician Orders, Statement of Diagnostic Test Results
   - ☐ Lab Results
   - ☐ X-ray and Imaging Reports
   - ☐ Other (please describe): _____
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
4. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
5. I release EOOC and the facility listed above, its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this authorization.

_____ _____

Signature of Patient or Legal Representative — Date

If signed by Legal Representative, relationship to patient: _____

_____ _____

Signature of Witness — Date

(If patient is a minor or unable to sign, complete the following)

_____ _____

Reason Unable to Sign — Signature of Parent, Guardian, or State Relationship

GOOD FOR 1 YEAR

Eastern Oklahoma Orthopedic Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.